Counseling Connection
Couples Questionnaire

Date: ____________________

Separate forms to be filled out by each party prior to the first session

The purpose of this questionnaire is to obtain a comprehensive picture of your relationship background. In counseling, records are necessary to facilitate a more thorough understanding of one's issues. Each of you are requested to answer these questions as fully and accurately as you can on this form in order to maximize your consulting time.

1. General Information

Client Name: ____________________ Age:___ Social Security# ____________

Address: ______________________________

____

Telephone Number (Days): ____________ (Evenings): ____________

DOB: ___/___/_____ Occupation: ____________ Place of Work: ____________

By whom were you referred? ______________________________

Who is your medical doctor/Pediatrician? ____________________ Phone: ____________

Notify in case of Emergency:

Name: ____________________ **Address:** ____________ **Phone:** ____________

Check all that apply:

Marital Status

☐ Never Married ☐ Divorced
☐ Married ☐ Separated
☐ Widowed ☐ Cohabitating

Race/Ethnic Origin (optional)

☐ White ☐ American Indian
☐ African American ☐ Asian
☐ Hispanic ☐ Bi-racial
☐ Other

Sex

☐ Male
☐ Female

Client's Present Living Arrangement

☐ Alone ☐ Friends ☐ Parents
☐ With Partner ☐ Other (please describe) ____________

Immediate Family	Age	Sex	Relationship	Living in Household: Yes	Living in Household: No	Occupation/Grade
Client						

Military Service: Yes ___No ___ Describe: ______________________________

Employment Status

☐ Full-time (35 or more hrs/wk)
☐ Employed, not working due to extended illness
☐ Full-time student
☐ Part-time (less than 35 hrs/wk)
☐ Homemaker
☐ Seasonal Worker
☐ Retired
☐ Unemployed
Other (please describe): ______________________________

Occupation: ______________________________

Education

High School/G.E.D. Yes_______ No __________
Last grade completed __________
Currently attending school/grade __________

Special Training ____________________
Highest Degree ____________________

Name: ______________________ Client ID ______________________

2. Description of Presenting Problem

State in your own words the nature of the problem that brought you and your partner to our office ________

Please describe significant events (e.g. divorce, illness, adoption, trauma, etc.) which may relate to the development or maintenance of your problems: ________

What previous solutions to your problems have been most helpful? ________

Have you been in counseling before or received any prior professional assistance for your problems? If so, please name(s), professional title(s), dates of treatments and results: ________

3. Special Issues

	Yes	No
Did you receive special educational assistance in school?	___	___
Were/are there any problems or concerns with performance or behavior at school/work	___	___
Were/are there any legal involvement or problems?	___	___
Are you experiencing financial problems?	___	___
Do you have any problems or concerns related to sexuality or your sexual orientation?	___	___
Has any member of your family, immediate or extended, been treated for an emotional or substance abuse problems?	___	___
Are there any family members who may have had emotional or substance abuse problems who were not treated?	___	___
Are there any cultural concerns, spiritual beliefs or values of which we should be aware?	___	___

If yes, please describe: ________

How much support do you get from your family, friends, church? (Please circle)

Great deal Some Little None

What community resources/self help groups are you currently utilizing? ________

4. Chemical Use History

Alcohol/Drug frequency/amount: ________

	Current	Past
Do you believe you have an alcohol or substance abuse problem?	☐ Yes ☐ No	☐ Yes ☐ No

Tobacco daily usage: ________ Caffeine daily usage: ________

Name: ______________________________ Client ID ______________

What do you believe to be your strengths? ______________________________

____

What do you believe to be your weaknesses? ______________________________

Additional Comments (Please include any other information you consider might be helpful to better understand the situation: ______________________________

____

3. Risk Assessment

	YES	NO
Currently suicidal?	___	___
Ever been suicidal?	___	___
Ever have suicidal thoughts?	___	___
Previously attempted suicide?	___	___
Ever deliberately harmed themselves in any way?	___	___
Have any thoughts about harming others in any way?	___	___

	YES	NO
Currently engaged in aggressive/violent behavior?	___	___
Have aggressive/violent thoughts?	___	___
Had aggressive/violent behavior or thoughts in the past?	___	___
Ever been hospitalized for psychiatric reasons?	___	___
Have any thoughts about harming themselves in any way?	___	___

4. Psychological Symptoms

PLEASE CHECK ALL THAT APPLY

Current		Past
☐	Depressed mood	☐
☐	Daily irritability	☐
☐	Lack of interest or pleasure in activities	☐
☐	Increase in appetite	☐
☐	Loss of appetite	☐
☐	Difficulty sleeping or poor sleep	☐
☐	Decreased need for sleep	☐
☐	Increased need for sleep	☐
☐	Tired or loss of energy	
☐	Feelings of worthlessness or guilt	☐
☐	Feelings of hopelessness	☐
☐	Recurrent thoughts of death	☐
☐	Racing thoughts or ideas	☐
☐	Distractibility	☐
☐	Rapid mood swings	☐
☐	Decreased ability to concentrate	☐
☐	Emotional/Psychological abuse	☐
☐	Physical abuse	☐
☐	Sexual abuse	☐
☐	Distressing memories that reoccur or intrude	☐
☐	Recurrent distressing dreams	☐
☐	Sense of reliving traumatic events	☐
☐	Periods of time you cannot remember	☐
☐	Intense reactions to certain events or Anniversaries	☐
☐	Avoidance of thoughts or feelings of trauma	☐
☐	Avoidance of activities or situations of Trauma	☐
☐	Detachment from feelings, people & places	☐
☐	Shortness of breath/dizziness	☐
☐	Accelerated heart rate or chest pains	☐
☐	Trembling or shaking	☐
☐	Sweating/feeling flushed	☐
☐	Choking	☐
☐	Nausea or abdominal distress	☐
☐	Feeling unreal	☐
☐	Numbness or tingling sensations	☐
☐	Fear of dying or going crazy	☐

Current		Past
☐	Excessive fear of persons,places, animal, objects, situations	☐
☐	Recurrent & persistent, thoughts	☐
☐	Behaviors excessively repeated	☐
☐	Bingeing/compulsive overeating	☐
☐	Intentional vomiting	☐
☐	Diuretics or laxative misuse	☐
☐	Excessive dieting	☐
☐	Compulsive exercising	☐
☐	Delusions (unreasonable thoughts or beliefs)	☐
☐	Hear or see things that other's don't?	☐
☐	Special powers/attributes	☐
☐	Not able to control impulse to steal	☐
☐	Preoccupation with/or frequent gambling	☐
☐	Restlessness or inability to concentrate	☐
☐	Difficulty making decisions	☐
☐	Fatigue or loss of energy	☐
☐	Difficulty focusing attention	☐
☐	Difficulty completing tasks	☐
☐	Easily distracted	☐
☐	Disorganized in daily tasks	☐
☐	Forgetful in daily activities	☐
☐	Loses track of items	☐
☐	Continual need to be on the go	☐

☐ Other symptoms (describe)

☐ ______________________________

☐ ______________________________

☐ ______________________________

Name: ______________________________ Client ID ____________________

5. Health/Medical Information

A.. What medical problems or concerns, if any, are you currently having?

____

____

B. Are those problems being treated? Yes. No By whom? ____________________

Last medical examination (date): ______________ Primary care doctor: ______________

What prescription or non-prescription drugs are you currently taking or have taken in the last six months?

1. (Med)____________________ (Dosage)________ (Taken for)____________________
2. (Med)____________________ (Dosage)________ (Taken for)____________________
3. (Med)____________________ (Dosage)________ (Taken for)____________________

ALLERGIES: Drug, food, other (list) Type of reaction

____________________ ____________________

____________________ ____________________

____________________ ____________________

If under 21 are your immunizations up to date? ☐ Yes. ☐ No. ☐ Unknown

Have you had dental problems in past year? ☐ Yes. ☐ No

If yes, describe: ____

Are you currently pregnant? ☐ Yes. ☐ No

Have you gained or lost more than 10 pounds in last year? ☐ Yes. ☐ No

Do you have nutritional concerns? ☐ Yes. ☐ No

How do you feel about your present weight? ☐ Satisfied. ☐ Neutral. ☐ Dissatisfied

Check any of the following that apply:

	Current	Past		Current	Past		Current	Past
Tuberculosis	☐	☐	Liver Disease	☐	☐	Heart Disease	☐	☐
Chronic Bronchitis	☐	☐	Ulcer (stomach)	☐	☐	Stroke	☐	☐
Emphysema	☐	☐	or Duodenus	☐	☐	Jaundice	☐	☐
Rheumatic Fever	☐	☐	Sexually transmitted			Hepatitis	☐	☐
Thyroid Disorder	☐	☐	disease	☐	☐	Asthma	☐	☐
Diabetes	☐	☐	Kidney Disorder	☐	☐	Anemia	☐	☐
Cancer	☐	☐	High Blood Pressure	☐	☐			
Epilepsy (Convulsions)	☐	☐	Pancreatitis	☐	☐			

Other: ____

Do you have any disabling conditions: Yes ___ No ___ If yes, describe: ____________________

Family history of serious illnesses, familial diseases (known or suspected): ____________________

____

III. List past hospitalizations (including psychiatric), operations, or serious illnesses:

	Type of Illnesses/Operations	Year	Hospital or Doctor
A.	____________________	______	____________________
B.	____________________	______	____________________
C.	____________________	______	____________________

Name: ______________________________ Client ID ____________________

6. **Relationship Issues/History**

Please give a brief history of your current relationship including where and when you met, significant events, history of relationship problems (use additional pages if necessary).

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____

____

____

____

Please describe your relationship strengths in the following areas:

Communication skills: ____

____

____

Conflict Management: ____

____

____

Sexual Interaction: ____

____

____

Child Management: ____

____

____

Time Management: ____

____

____

Commitment to Each Other: ____

____

____

Demonstration of Caring/Support: _____________________________________

____

____

Ability to Trust One Another: ____

____

____

Name: ______________________ Client ID ____________

Expression of Feelings/Moods: ______________________

____

____

Willingness to Change: ______________________

____

____

Please give a brief history of significant relationships prior to your current one (dating, past marriages, divorces, etc.) that may provide useful information for your current counseling. ______________________

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____

____

____

____

Goals for Relationship

Please list specific goals for your relationship:

1. ______________________
2. ______________________
3. ______________________

Please list specific goals for **self**-improvement that you feel would enhance your relationship:

1. ______________________
2. ______________________
3. ______________________

Please list specific changes in your partner's behavior that you feel would help achieve your relationship goals:

1. ______________________
2. ______________________
3. ______________________

Further comments or goals not covered in this questionnaire: ______________________

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Client's Signature: ______________________ Date: ____________

Therapist's Signature: ______________________ Date: ____________